

March 25, 2002



**Center for Health and
Public Policy Studies**

California Health Care Options Project

The CHOICE Option

Submitted to the California Health and Human Services Agency
March 31, 2002

Prepared by:
Helen Halpin Schauffler, Ph.D.

With significant contributions from*:
Sylvia Guendelman, Ph.D., Joyce Lashof, M.D., Sharon Levine, M.D., Sara
McMenamin, Ph.D., Patricia Powers, M.P.P., and Sara Singer, M.B.A.

Contact:
Helen Halpin Schauffler, Ph.D.
Professor of Health Policy
Director, Center for Health and Public Policy Studies
School of Public Health, University of California
140 Warren Hall, MC #7360
Berkeley, CA 94720-7360
Phone: (510) 643-1675
Fax: (501) 643-2340
E-mail: helenhs@uclink.berkeley.edu

*Contributions do not imply endorsement of the full proposal.

TABLE OF CONTENTS

Summary of the CHOICE Program	5
1. Understanding the Problem	7
II. Objectives of the CHOICE Program	9
A. To Increase Coverage	9
B. To Increase Choice	9
C. To Increase Equity	10
D. To Increase Efficiency	10
E. To Increase Security	11
III. Mechanisms for Expanding Coverage	12
A. Affordable and Equitable Out-of-Pocket Premium	12
B. Employer Payroll Tax	12
C. Extensive Community Outreach	12
IV. Eligibility for CHOICE	13
A. Target Populations	13
B. Eligibility Criteria	14
C. Coverage Options	15
V. Benchmark for CHOICE Health Benefits	16
A. A Values-Based Approach to Benefit Design	16
B. Initial Standard Benefit Package	17
C. Pharmacy Benefits	18
D. Co-payments	18
VI. CHOICE Financing Mechanisms	19
A. Existing State Funding	19
B. Existing Federal Funding	19
C. Worker's Share of Premium	19
D. Funding for Elderly Medicare Beneficiaries	21
E. State Payroll Tax on Firms	21
F. Public Health Taxes	24

G. State Safety Net Savings	25
H. Other Sources of State Revenue	25
I. Potential Funding under NAFTA	26
VII. CHOICE Administration and State Regulation	28
A. Administration by MRMIB	28
B. The CHOICE Network and Provider Payments	29
C. Contracts with ODS	31
D. Regulation	33
E. Insurance Risk	33
F. Community Outreach	33
VIII. Quality and Data Incentives Under CHOICE	34
A. Quality Assumptions	34
B. Patient Care Management	35
C. Provider Performance Measurement and Improvement	36
D. Patient Incentives	37
E. Provider Incentives	37
IX. CHOICE Implementation Approach and Feasibility	38
A. Implementation Steps	38
B. How CHOICE Affects Coverage and the Market	39
C. How CHOICE Affects the Safety Net	41

Figures and Tables

Figures

Figure 1.	CHOICE Program Administration	43 (Appendix)
Figure 2.	Distribution of California Residents by Primary Source of Coverage Under Current Policy and The CHOICE Program in 2002	40

Tables

Table 1.	Worker Monthly Out-of-Pocket Premium Under CHOICE	20
Table 2.	Impact of the CHOICE Program on Household Health Care Expenditures	21
Table 3.	Employer Payroll Tax Under CHOICE	22
Table 4.	The Impact of CHOICE on Private Employer Health Spending Before Wage Effects	23
Table 5.	Sources of Funds for the CHOICE Program, Medi-Cal and Healthy Families	26

SUMMARY OF THE CHOICE PROGRAM

The CHOICE Program is designed so that all of the health insurance options Californians presently have are retained and no one is forced to change their coverage. However, CHOICE offers Californians a new option that is designed to meet their preferences as patients, health care providers, and employers. The CHOICE Program was developed based on experiences over the last 40 years under private fee-for-service and managed care systems, as well as under the Medicare and Medi-Cal programs. Every effort has been made to retain those features of these systems and programs that foster the underlying goals of security, equity, liberty and efficiency and to eliminate those features that are contrary to achieving these goals. The economic incentives in the CHOICE Program are designed in such a way that nearly all employers and more than 70% of non-elderly Californians will elect to enroll and get their coverage through CHOICE. The CHOICE Program is estimated to result in coverage for 94.4% of all Californians of all ages, regardless of their legal status.¹

The key principles embedded in the CHOICE Program are the following:

- Everyone pays their fair share of health insurance costs and only what they can afford.
- Administrative waste and associated costs are reduced and administrative processes are simplified and made more rational.
- Individuals, employers, and health care providers have freedom in their selection of health care systems and type of health insurance.
- Comprehensive coverage is provided to ensure access to high quality health care.
- Benefit design places the greatest importance on prevention and management of disease and disability, steering patients to centers of excellence for their acute care needs, and limiting out-of-pocket costs that act as barriers to receiving needed care.
- Health care providers receive reasonable and fair payments for the services they deliver in an effort to retain and recruit the best health care professionals for Californians.
- Medical care decision-making is returned to health care professionals and their patients, while health care providers are held accountable for the care they deliver.

Thus, the CHOICE Program will reform California's health care system through the voluntary actions of individuals, employers, and health care providers based on their preferences

and economic incentives. The CHOICE Program involves no state mandates of individuals, no regulation of employer-sponsored health benefits, no new Federal waivers, no additional Federal funding, and no ERISA waiver. Rather, it restructures current payment mechanisms and adds new choices such that 94.4% of all Californians will have comprehensive, affordable health insurance coverage, with access to high quality health care services that promote their health, within one year of implementing the CHOICE Program.²

All Californians who elect to enroll in CHOICE will have two major options for affordable, comprehensive health insurance coverage:

- 1) to get their medical care from any licensed health care professional or facility that contracts with the statewide CHOICE fee-for-service network for provision of covered services. Providers may elect to participate in the CHOICE Network or not.
- 2) to enroll in any state licensed organized delivery system (ODS) including group model HMOs, County Organized Health Systems (COHS), or Local Initiative (LI) plans that contract with the CHOICE Program. Eligible ODS may elect to participate in CHOICE or not. Health insurance carriers and health plans will be offered state tax incentives to partner with large multi-specialty groups in exclusive arrangements to create new ODS.

The Major Risk Medical Insurance Board (MRMIB) will administer the CHOICE Program. The program is fully funded. Existing sources of financing include: the State and Federal share-of-cost for those who are eligible under Healthy Families and Medi-Cal; state funding for those who are eligible under MRMIP (Major Risk Medical Insurance Program) and AIM (Access for Infants and Mothers Program), 80% of the savings in the State's and counties' direct subsidies for indigent medical care (does not include federal DSH payments) resulting from insurance coverage of those who were previously uninsured. This will result in an increase in per capita State funding of indigent care programs for the remaining uninsured population. New sources of financing include a wage-based, capped monthly premium (for those who choose to enroll), a quarterly employer payroll tax that varies by firm size (and is refundable for employees who are covered under the employer's plan), three public health taxes (\$1 tax increase per pack of cigarettes, an increase in the surcharge on motor vehicle fines, a ten cent tax

¹ The Lewin Group, Inc. The CHOICE Coverage Expansion Program for California: Summary and Estimated Cost and Coverage Impacts. Final Third Round Estimates. Prepared for the California State Planning Grant, California Health and Human Services Agency (CHHS). Health Benefits Simulation Model (HBSM) March 25, 2002.

² The Lewin Group, Inc., HBSM *op cit*.

per 12-ounce can of soda), an 0.25% increase in the sales tax, a 1.25% increase in the state income tax, and funding from the proposed NAFTA Social Integration Fund to help finance health insurance coverage under CHOICE for Mexican citizens who reside and work in California.

I. UNDERSTANDING THE PROBLEM

Perhaps the most important first step in trying to craft a public policy solution to a problem is the clear definition of the problem to be solved. The CHOICE Program was developed and designed to respond directly to the most significant problems faced by California's health care system in 2002.

In defining the problem and designing a solution, we find that:

- Approximately 6.2 million Californians lacked any health insurance coverage in 2000.³
- Millions of Californians are enrolled in IPA-model HMOs and are restricted, under the delegated model, to only one medical group in their selection of physicians, while at the same time they face significant barriers to access covered services and needed care.⁴
- Californians are willing to pay for affordable, comprehensive health insurance.⁴
- Californians want to be able to choose their own doctors and hospitals for covered care.⁴
- Californians want their health care providers to have the authority to make medical decisions with them about their care.⁴
- Some large firms (>50 workers) would like to get out of the business of providing health insurance coverage, and most small firms (2-50 workers) would like to offer health benefits but cannot afford the cost of coverage in the small group market.⁵ In addition, many self-employed Californians would like to purchase health insurance coverage.
- Health care providers would like to receive fair and reasonable payment for the services they deliver.
- Approximately 6 million Californians are enrolled in Kaiser Foundation Health Plan, which contracts exclusively with the Permanente Medical Groups in California. Californians

³ Current Population Survey, March 2001.

⁴ California Managed Health Care Improvement Task Force Report, January 1998.

⁵ Schauflier HH, Brown ER et al. The State of Health Insurance in California , 1998. February 1999. Regents of the University of California.

enrolled in Kaiser are among the most satisfied patients in the state, and Kaiser has been a value leader based in its performance on quality of care and costs.⁶

- Too little of the financing for health care is going to the delivery of patient care and too much is being spent on duplicative administrative structures and processes, and inefficient bureaucracy.
- The federal Medicare program does not cover important benefits, including preventive care, prescription drugs or long-term care, and the number of options available to the elderly under the Medicare+ CHOICE Program is decreasing in California, while their out-of-pocket costs are increasing.

In trying to answer the question of how to increase health insurance coverage for more Californians, it is also important to ask, “to what kind of health care system do we want to extend access?” The CHOICE Program restructures the financing, incentives, and options in the current health care system for patients and providers, as well as for employers, to build a system in which:

- Californians have affordable health insurance coverage for comprehensive, high quality health care.
- Californians can choose their own doctors and hospitals in a statewide network and also have a choice of eligible organized delivery systems (ODS) for their care.
- Physicians have the authority to make medical decision about patient care without pre-approval or authorization.
- All employers contribute toward the financing of health insurance for their workers through a required quarterly payroll tax that costs them significantly less than what those who offer coverage through the group market pay today, and those employers that choose to offer their own coverage will receive a refund on the payroll tax for those workers who elect to be covered through the employer-sponsored health plan.
- Health care providers and facilities are fairly compensated at 100% of Medicare fee-for-service rates for the covered services and are rewarded for high quality and appropriate provision of preventive care and disease management services.
- Costs are continuously monitored and kept reasonable.
- Californians maximize value for their health-care dollars.

⁶ Pacific Business Group on Health, California Consumer HealthScope, 1997 California Blue Ribbon HMO.

II. OBJECTIVES OF THE CHOICE PROGRAM

The CHOICE Program has five major objectives:

A. To Increase Coverage

The primary objective of the CHOICE Program is to increase access to affordable, comprehensive health insurance coverage for all California's non-elderly workers (regardless of their legal status) and their families, and for elderly Californians who are eligible for Medicare. A worker is broadly defined to include full-time, part-time, seasonal, contractual, and temporary workers, as well as the self-employed. An analysis of the impact of the CHOICE Program on coverage finds that 94.4% of all Californians would be covered after the CHOICE Program is adopted; CHOICE would reduce the proportion of Californians lacking health insurance from 19% to less than 6%.⁷ The CHOICE Program will extend eligibility for coverage to approximately 4.8 million currently uninsured Californians and their families. It also will increase enrollment, through mass media campaigns and extensive community outreach, for 124,000 Californians who are eligible for Healthy Families and the Medi-Cal Program but are not enrolled. It will also provide an option for more comprehensive and affordable coverage for elderly Medicare beneficiaries who elect to enroll in the CHOICE Program through a federal Medicare Demonstration Program.

B. To Increase Choice

All California workers and their non-working dependents, as well as elderly Medicare beneficiaries, will have the option of enrolling in the CHOICE Program or not. The CHOICE Program gives:

- Workers and their families the option of getting their coverage through their employer (if offered), public programs (if eligible), the individual market, or the CHOICE Program.
- Elderly Medicare beneficiaries the option of getting their coverage through the traditional Medicare program, Medicare+ Choice plans, or the California CHOICE Program.
- Employers the option of deciding whether or not to offer employer-sponsored coverage.
- CHOICE enrollees the option of selecting between the statewide CHOICE Network or participating ODS for their medical care.
- CHOICE enrollees the option of choosing their own doctors and hospitals from among those participating in the statewide CHOICE Network.

- Health insurance brokers the option of offering the CHOICE Program to individuals and small firms.
- Health insurance companies and health plans the option of continuing to sell coverage in the group and individual markets and to partner in exclusive arrangements with multi-specialty medical groups to form new ODS that may contract with the CHOICE Program.

C. To Increase Equity

An objective of the CHOICE Program is that: *EVERYONE PAYS A FAIR SHARE OF THE COST* to support access to comprehensive, affordable coverage for Californians and their families. The CHOICE Program achieves financial equity by requiring that all parties (individuals, employers, and state, county and federal governments) that currently support the health care system financially continue to do so at a level that is affordable and necessary to provide comprehensive, high quality health care services. The CHOICE Program also increases equity by:

- Making premium contributions affordable by tying them to wage levels up to a maximum annual wage. There is no out-of-pocket premium for individuals and families with annual incomes below 150% of poverty. On average, Californians with incomes above 150% of poverty would pay 2% of their annual wage applied to a maximum wage of \$80,000 per year.
- Providing a reasonably comprehensive standard set of benefits to all enrolled Californians.
- Providing fair payment to all health care providers in the CHOICE Network through 100% Medicare fee-for-service payments. On average, the CHOICE Program will increase Medi-Cal payments to physicians by 54% and will reduce uncompensated care by 76%.⁸
- Providing participating ODS with an age and sex, risk-adjusted capitation payment for all covered services for their CHOICE enrollees.

D. To Increase Efficiency

Another objective of the CHOICE Program is to increase efficiency in the administration of health insurance coverage and to purchase greater value with California's health care dollars. This means maintaining and improving the quality of health care, while at the same time keeping costs reasonable. This objective will be achieved by:

- Taking advantage of electronic processing capabilities for all administrative functions.

⁷ The Lewin Group, Inc. HBSM *op cit*.

⁸ The Lewin Group, Inc. HBSM, *op cit*.

- Bulk purchasing of pharmaceuticals and medical equipment under CHOICE through the Federal Supply Schedule (FSS).
- Coordinating the administration of the CHOICE Program with the other programs administered by MRMIB and with the Medi-Cal Program.
- Permitting any requirements for income, residency, and work to be determined by a self-certification process with random paperless verification.⁹
- Permitting automated enrollment in CHOICE by health care professionals at the site of care (this alone is estimated to save \$194 million in State and Federal funding).¹⁰
- Contracting directly with licensed health care professionals and facilities in the statewide CHOICE Network, whose performance will be assessed on quality and value.
- Restricting contracts with ODS to only state licensed group-model HMOs, County Organized Health Systems (COHS), and Local Initiative (LI) plans whose performance will be assessed on quality and value.¹¹
- Increasing the number of insured individuals, thereby providing a reliable source of new revenue for safety net providers, and at the same time increasing per capita State funding for indigent medical care for persons who remain uninsured.¹²

E. To Increase Security

In the end, the primary goals of California's health care system should be to maintain and improve the health of the people of California and to meet their medical care needs. This means preventing disease and disability, promoting health, managing chronic conditions, treating illness and injury, and giving priority in coverage to those services that have been demonstrated to improve health outcomes. This objective will be achieved by:

- providing coverage for those services and treatments that have been demonstrated to be effective and relatively cost-effective in the prevention, diagnosis, treatment, and management of a medical condition.
- holding health care providers in the CHOICE Network and the ODS contracting with the CHOICE Program accountable for the quality and the cost of the care they deliver.
- returning medical care decision-making to health care providers and their patients.

⁹ Ana Montes, Latino Issues Forum, Memo to Norma Garcia of Consumers Union re: Self-Certification, 4/20/99.

¹⁰ The Lewin Group, Inc., HBSM *op cit*, p. 14.

¹¹ UC Berkeley Annual Survey of Health Plans, 1997.

¹² LAO analysis, 2001

III. MECHANISMS FOR EXPANDING COVERAGE UNDER CHOICE

There are three major mechanisms for expanding coverage under the CHOICE Program.

A. Affordable and Equitable Out-of-Pocket Premium

One of the biggest barriers to health insurance coverage for most uninsured Californians is affordability. Thus, one mechanism for expanding coverage is to tie individual/family premium contribution levels to worker's wages (up to the Social Security maximum annual wage), making health insurance affordable for all Californians and their dependents. The impact of the CHOICE Program on household spending for health insurance would result in an annual savings of nearly \$3 billion for individuals and their families.¹³

B. Employer Payroll Tax

Most Californians with health insurance receive their coverage through their employer (61%), yet in 1999, 39% of the self-employed were uninsured, and only 41% of small firms with 3-9 workers, and 62% of small firms with 10-50 workers offered health insurance coverage. Most small firms would like to offer coverage, but report that they cannot afford the cost.¹⁴

While firms are not required to offer coverage under the CHOICE Program, they are required to pay a modest payroll tax that is significantly less than the average cost of coverage in the group market -- a 15% savings (or \$4.8 billion in the first year alone) for firms that now offer coverage.¹⁵ Thus, all workers and their non-working dependents in all firms will have the option of enrolling in the CHOICE Program when the payroll tax goes into effect, or getting their coverage through their employer, if it is offered. The payroll tax is refundable to the firm for the proportion of a firm's total payroll that is represented by the workers in the firm who are covered by employer-sponsored health benefits (and not by the CHOICE Program).

C. Extensive Community Outreach

The State will conduct a massive media campaign and extensive community outreach through schools and health care providers and facilities to enroll eligible persons in the Medi-Cal Program, Healthy Families, and/or the CHOICE Program. Any uninsured individual may be enrolled in CHOICE at the site of care through an automated verification system and health care providers will be paid 100% Medicare fee-for-service payments for the care they provide. The CHOICE Program will coordinate with the State Health Department in creating and

¹³ The Lewin Group, Inc. HBSM *op cit*.

¹⁴ Kaiser/HRET/UC Berkeley California Employer Health Benefits Survey, 1999.

implementing media campaigns and outreach programs to enroll Californians in eligible programs. To this end, the CHOICE Program will also work with employers to inform all workers about their eligibility. It is estimated that this will reduce the number of uninsured adults and children in non-working families who are eligible for but not enrolled in Medi-Cal and Healthy Families by 28% (or 124,000 Californians). However, this will leave 72% of these persons or approximately 320,000 Californians eligible for health insurance but not enrolled.¹⁶

IV. ELIGIBILITY FOR THE CHOICE PROGRAM

A. Target Populations

The primary target population for enrollment in CHOICE is the estimated 6.2 million uninsured Californians in 2000 who are 0 to 64 year and not eligible for Medicare. However, the specific target populations that will be eligible to enroll in the CHOICE Program are much broader and include the following groups (these categories are not mutually exclusive):

1. Working Uninsured Families

The primary target population is the 6 million uninsured Californians ages 0-64 who are in working families and are not eligible for Medicare.

2. Californians Who Are Eligible for Public Programs But Not Enrolled

Another target population is the one million uninsured Californians (ages 0-64) and their families who are eligible for but not enrolled in Healthy Families or Medi-Cal.

3. Californians with Employer-Based and Individual Health Insurance

Another target population for the CHOICE Program is the 20 million Californians ages 0-64, who have health insurance coverage, but which lacks affordability, continuity, or sufficient choice of physicians and hospitals. These include Californians who: are enrolled in IPA/network model HMOs; pay very high premiums in the individual market or in MRMIP; are under financial distress as a result of their employee share of premium; or are offered no choice of health plans through their employer. The CHOICE Program offers these Californians the option of affordable, comprehensive coverage with access to either the statewide CHOICE Network or eligible ODS.

¹⁵ The Lewin Group, Inc. HBSM, *op cit.*

¹⁶ The Lewin Group, Inc. HBSM *op cit.*

4. Californians in Healthy Families and the Working Medi-Cal Population

Another target population for the CHOICE Program is working Californians (ages 0-64) and their non-working dependents who are covered by Healthy Families and the Medi-Cal Program, but who want a greater choice of health care providers for their medical care, want their physicians to receive fair and competitive compensation for the health care services they provide, and want their doctors to make unencumbered decisions about their medical care and specialty referrals. Workers and their non-working dependents, who are eligible for and/or enrolled in the Medi-Cal Program and Healthy Families may elect to enroll in the CHOICE Program. Persons eligible for Healthy Families and Medi-Cal will retain both the Federal share-of-cost and state match to finance their CHOICE coverage.

5. Elderly Californians Covered Under Medicare

Another target population is the 3.6 million elderly (65 years and older) Californians who are enrolled in Medicare and are unhappy with their lack of coverage for prescription drugs, and preventive care, their high out-of-pocket costs for deductibles and co-insurance under the traditional Medicare program, and with the Medicare+ Choice Plans (HMOs) that restrict their choice of providers and are dropping coverage of supplemental benefits to control costs. The State will apply to the Centers for Medicare and Medicaid Services (CMS) to obtain approval to conduct a federal demonstration program to offer the California CHOICE Program as an option to those elderly Medicare beneficiaries who would like to enroll and pay their share of premium. Enrollment in CHOICE for elderly Medicare beneficiaries will be completely voluntary.

B. Eligibility Criteria

Californians who meet the following criteria are eligible for the CHOICE Program regardless of race, age, gender, religion, ethnicity, sexual orientation, legal status, health status, or income.

Eligibility for Non-Elderly Californians

Non-elderly (0-64 years) Californians who meet all three criteria below are eligible to enroll in the CHOICE Program:

1. Presently reside in California with the intent to remain.¹⁷
2. Not covered by Medicare.

¹⁷ The language of “present with intent to remain” is used to determine Medi-Cal eligibility.

3. Meet one of the following criteria:

- Worked in California (or the non-working dependent(s) of an eligible worker) for at least 3 months out of the last 12. A worker is defined to include full-time, part-time, seasonal worker, contractual workers, and the self-employed.
- Eligible for COBRA health benefits.
- Receiving state unemployment benefits.

Eligibility for Elderly Californians

- 65 years of age or older
- Presently reside in California with the intent to remain.
- Eligible for Medicare.

Eligibility for Other Californians

Non-working, non-elderly Californians and uninsured elderly Californians can buy into the CHOICE Program by paying the full premium. However, persons enrolled in Military/CHAMPUS programs are not eligible for the CHOICE Program, and non-working adult (18 and older) Californians who are eligible for or enrolled in the Medi-Cal Program will not be eligible to enroll in the CHOICE Program, but will remain covered under Medi-Cal.

Guaranteed Annual Renewal

Individuals and families who elect to enroll in the CHOICE Program will have coverage for one full year. Once an individual/family has enrolled, annual renewal is guaranteed, conditional on continued payment of their share of the premium.

C. Coverage Options Under CHOICE

All Californians who elect to enroll in CHOICE will have two major options for affordable, comprehensive health insurance coverage:

- 1) to get their medical care from any licensed health care professional or facility that contracts with the statewide CHOICE fee-for-service network for provision of covered services. Providers may elect to participate in the CHOICE Network or not.
- 2) to enroll in any state licensed organized delivery system (ODS) including group model HMOs, County Organized Health Systems (COHS), or Local Initiative (LI) plans that contract with the CHOICE Program. Eligible ODS may elect to participate in CHOICE or not. Health insurance carriers and health plans will be offered state tax incentives to partner with large multi-specialty groups in exclusive arrangements to create new ODS.

V. BENCHMARK FOR CHOICE HEALTH BENEFITS

A. A Values-Based Approach to Benefit Design

A comprehensive standard set of benefits is one of the keys to the CHOICE Program. Health benefit design sits at the center of the debate over the tradeoffs between access, choice, quality, and costs. Health benefit design is the determination of what is covered by insurance and what is not. One of the biggest drivers of improvements in health care quality and growing health care costs is the increasing availability of new technology and pharmaceuticals, including diagnostic and therapeutic interventions. Direct-to-consumer advertising has increased patient demand for specific drugs and treatments, as have the actions of political advocates who have pressured state governments to mandate coverage of specific services or prescription drugs for groups with particular conditions.¹⁸ The result is often an irrational process for determining which services and treatments are covered or not. Instead, CHOICE benefits will be selected by determining which treatments and services are most effective in maintaining and improving health and quality of life, as well as those that are relatively cost-effective.

CHOICE offers a more rational framework for determining what new technologies and pharmaceuticals will be covered. An independent state panel of experts composed of physicians representing the major specialties will be established to advise the CHOICE Program on the specific interventions, treatments, or drugs which should be added or removed from the standard benefit package.

To preserve affordability and prevent erosion of comprehensive benefits, selection of benefits should be based on evidence that establishes the likelihood that a given procedure, intervention or drug will produce genuine health benefits. CHOICE must also enable the coverage of interventions based upon the cost-effectiveness of the procedure, intervention, or drug relative to other comparably effective therapies for the same condition or symptom complex. The decision making process also needs to permit the categorical exclusion from coverage of treatments deemed inappropriate for insurance coverage for utility or reasons of moral hazard, or because the benefit of including them is far outweighed by the risk the cost poses to the affordability of the comprehensive benefit package.

¹⁸ Schauffler HH. Politics trumps science: rethinking state-mandated benefits. American Journal of Preventive Medicine 2000 19(2):136-137.

With nearly universal coverage (94.4%) under the CHOICE Program, its stable aggregate risk pools, and an evidence-based approach to covered benefits, we can achieve broad access to comprehensive benefits likely to produce desired health outcomes in a cost-effective manner. Such a process would minimize obstacles to receiving effective treatments and promote access to appropriate health-value-added care including primary prevention, early disease identification and treatment, and management of chronic conditions. This approach is much more preferable than using the blunt policy tools of higher and higher deductibles, co-insurance and copayments that have been demonstrated to reduce utilization, and which are indiscriminate -- reducing the use of both appropriate services and marginal/low value services to the same degree. The CHOICE Program would enable ODS and health care providers to compete based on effectiveness and efficiency of care delivery and health status improvement, rather than competition based on underwriting, risk avoidance, cost-cutting, and risk pool manipulation, all of which the current system encourages.

B. Initial Standard Benefit Package Under CHOICE

The Kaiser Foundation Health Plan standard benefit package in the large group market is the benchmark for health benefits under the CHOICE Program. These benefits include, but are not limited to, coverage of hospital care, outpatient care, prescription drugs, preventive care, maternity care, mental health care, supplies and supplements, ambulance services, dialysis care, alcohol or drug dependency treatment, durable medical equipment, emergency care and out-of-area urgent care, family planning, hospice care, vision care, health education, hearing care, home health care, imaging, lab tests and special procedures, ostomy and urological supplies, physical, occupational and speech therapy, multidisciplinary rehabilitation, prosthetic and orthotic devices, reconstructive surgery, skilled nursing facility care, and transplants. This benefit package was selected because it is relatively comprehensive, was determined through a process of clinical review, and designed to promote the health and meet the medical care needs of the covered population.

Payments for covered services will only be made to health care providers that contract with the Statewide CHOICE Network and to ODS that contract with the CHOICE Program. Payments for out-of-network providers will be made for CHOICE enrollees only for emergency and out-of-area urgent care.

Supplemental coverage will be provided to cover benefits now covered under Medi-Cal and Healthy Families that are not covered under the CHOICE Program so that no one loses any benefits for which they are eligible under these public programs (e.g., long-term care under Medi-Cal and dental care for children under Healthy Families).

C. Pharmacy Benefits

Pharmacy management is a critical aspect of both cost and quality of care. A state pharmacy and therapeutics committee will be comprised of independent physicians, pharmacists, consumers and others to oversee the CHOICE formulary process. Prescription drugs under the CHOICE Program will be purchased through the Federal Supply Schedule which will make them much more affordable compared to current market prices.

D. Co-Payments

There will be no co-payments required for receipt of covered preventive services (screening, immunization, or counseling services) in the CHOICE Program. There will also be no co-payment requirements for enrollees who select the CHOICE Network and whose annual wages are less than 150% of the federal poverty level. For enrollees in the CHOICE Network whose coverage is in part financed through Medi-Cal or Healthy Families, co-payments will not exceed the requirements under these programs.

Co-payments for enrollees who select the CHOICE Network and whose annual wages are above 150% of the federal poverty level (and whose coverage is not financed by Medi-Cal or Healthy Families) will be set initially at \$10 per outpatient visit.¹⁹ Emergency room copayments are \$35 per visit. There is no co-payment, deductible or co-insurance for inpatient care.

Drug co-payments for enrollees who select the CHOICE Network and whose annual wages are above 150% of the federal poverty level (and whose coverage is not financed by Medi-Cal or Healthy Families), will vary by generic/brand and formulary/non-formulary drugs, as is true in the private sector across nearly all health plan types. The co-payments for a one-month prescription will be four-tiered: generic drugs (\$5), brand name drugs with no generic available (\$10), brand name drugs with generics available (\$20), and non-formulary drugs (25% of cost).

¹⁹ 50% of covered workers in HMOs in 2001 had a co-payment requirement of \$10. KFF/HRET Employer Health Benefits 2001 Annual Survey.

V. CHOICE FINANCING MECHANISMS

There are nine major sources of financing for the CHOICE Program that are detailed below.

A. Existing State Funding

State funding for the CHOICE Program will come from a variety of sources:

- The State will pay its share-of-cost for workers and their dependents who are eligible for the Medi-Cal Program and who elect to enroll in the CHOICE Program.²⁰
- The State will subsidize the cost of “high risk” enrollees in the CHOICE Program through funds appropriated for MRMIP.²¹
- The State will pay its share-of-cost for persons eligible for Healthy Families who enroll in the CHOICE Program.²²
- The State will pay its share-of-cost for workers eligible for the AIM program who enroll in the CHOICE Program.²³

B. Existing Federal Funding

The Federal government will pay its share-of-cost (federal match) for persons eligible for Healthy Families and Medi-Cal who enroll in the CHOICE Program.

C. Worker’s Share of Premium

Workers who elect to enroll in the CHOICE Program will pay a fair share of the cost of the monthly premium that varies as a function of their monthly wage and the number of non-working dependents in their family. The premium is structured so that those who can afford to pay more are asked to pay a larger share of the premium compared to those who are lower income. Most individuals or families enrolled in the CHOICE Program will be asked to pay no more toward the annual premium than 2% of their total wages, applied up to the maximum annual wage per worker subject to the Social Security payroll tax (which was approximately \$80,400 in 2001). Workers with wages below 150% of the federal poverty level will not be required to pay any out-of-pocket monthly premium.²⁴ Workers who are eligible for Med-Cal or

²⁰ HCFA Final Management Report for FY 2000. hcfa.gov/meidcaid/fmr00.zip

²¹ MRMIP Subscriber and Health Plan Data: July 2001 Summary. www.mrmib.ca.gov/MRMIB/MRMIPRptSum.html

²² Federal Register/Vol. 65, No. 101/Wednesday, May 24, 2001/Notices, 33643, State Children’s Health insurance program Allotments for Federal Fiscal Year.

²³ AIM Subscriber and Health Plan Data. July 2001 Summary. www.mrmib.ca.gov/MRMIB/MRMIPRptSum.html

²⁴ Individuals/families with incomes below 150% of the federal poverty level will pay no out-of-pocket share of premium to enroll in the CHOICE Program and no co-payment for services or pharmaceuticals. Enrollees in the

Healthy Families will not be required to pay a premium that exceeds the requirements of those programs. The self-employed pay the worker's share of premium for themselves and their non-working dependents.

Workers in firms that decide to offer employer-sponsored coverage may elect to enroll in the CHOICE Program. Persons who take employer-sponsored coverage are responsible for their share of the premium under the employer's plan. Workers who take coverage under the CHOICE Program pay the wage-based share of the CHOICE premium, but would not pay the premium under the employer's plan. The CHOICE Program does not require workers to take coverage under either their employer's plan (if offered) or the CHOICE Program. Thus, workers retain the option of not taking health coverage and not paying a premium, with no individual mandate to have coverage.

Table 1 presents the share of the monthly premium each worker who enrolls in the CHOICE Program will be required to pay as a function of their monthly wage relative to the federal poverty level and the number of non-working dependents in their family.

Table 1
Worker Out-of-Pocket Monthly Premium Under the CHOICE Program

Worker Annual Wage ^{1, 2, 3}	% monthly wage per worker	Additional % monthly wage for each non-working dependent	Maximum % of monthly wage per worker
Up to 150% of poverty	0%	0%	0%
From 151%-250% of poverty	0.5%	0.5%	2%
From 251-350% of poverty	1.5%	0.5%	2%
350%+	2%	0.5%	2.5%

¹ Individuals enrolled in the CHOICE Program who are eligible for the Medi-Cal Program or Healthy Families will be required only to pay the premium that is required under these programs.

² Based on the worker's monthly wage up to the annual wage cap for Social Security payroll taxes (~\$80,400 annual wage in 2001).

³ The same rates and restrictions would apply to income of elderly Medicare beneficiaries who voluntarily enroll in CHOICE through the CMS Demonstration Program

CHOICE Program through no-cost Medi-Cal will also face no premium cost or copayments if enrolled in the CHOICE Program. Premiums and copayments for persons enrolled in the CHOICE Program through Healthy Families or share-of-cost Medi-Cal will not exceed the requirements under these programs.

It is estimated that household spending will decline by \$3 billion under the CHOICE Program. This includes the reduction of household premium payments for private health insurance (\$2.1 billion) and reduced household out-of-pocket payments for health services (\$6.1 billion). Table 2 shows the impact of the CHOICE Program on household spending.

Table 2

Impact of the CHOICE Program on Household Health Care Expenditures (in millions)

	Without Wage Effects	With Wage Effects
Premium Reductions	(\$2,052)	(\$2,052)
Reduced Out-of-Pocket Spending for Acute Care	(\$6,119)	(\$6,119)
Dedicated Program Tax Payments	\$5,217	\$5,217
After-Tax Wage Effects	N/A	\$250
Net Change in Household Spending		
Net Impact on Household Spending	(\$2,954)	(\$2,704)

Source: Lewin Group estimates using the Health Benefits Simulation Model, 3/25/02

D. Funding for Medicare Beneficiaries Who Voluntarily Enroll in CHOICE

The premium for elderly Medicare beneficiaries who voluntarily elect to enroll in the CHOICE Program under the state's proposed CMS Demonstration Program will be funded in three ways:

- An income-based share of premium (see worker share of premium above for rates), not to exceed 2.5% for those in the highest income brackets and applied to an annual income capped at the Social Security maximum of about \$80,000 per year.
- The federal Medicare+ Choice capitation payment from CMS.
- For those who have retiree health benefits, the amount the employer pays to purchase retiree health benefits will be paid to the CHOICE Program for each eligible Medicare beneficiary who voluntarily enrolls in CHOICE.

E. State Payroll Tax on Firms

Recent estimates suggest that the employer share of premium paid by firms that offer coverage is approximately the equivalent of a 7% payroll tax. The payroll tax under the CHOICE Program is set so that it will be considerably less costly for nearly all firms in California (a 5.5% tax for small firms and 6.5% tax for large firms) to pay the tax and encourage

their workers to enroll in CHOICE compared to offering employer-sponsored coverage that is self-insured or purchased in the group health insurance market. Among California employers who currently offer coverage, their spending would decline under the CHOICE Program by \$4.8 billion in the first year.²⁵ The new cost to firms that do not presently offer health benefits would be approximately \$5.5 billion. These changes in private employer health spending vary by firm size and total payroll. The net total cost of CHOICE to employers in the first year would only be \$701 million.²⁶

All firms operating in California will pay a quarterly state payroll tax to help finance the CHOICE Program based on firm size and total payroll. The self-employed are treated as small firms of one employee for the purposes of the payroll tax. The tax is on all wages, tips, and salaries. The tax applies to the total payroll across all workers. Firms will be categorized by size with smaller firms paying at a lower rate than larger firms (small firms have 1-50 workers; large firms have 51+ workers). Low payroll taxes for small firms recognizes the difficulty that these firms have in affording coverage, as well as their reported desire to be able to offer their workers health benefits. The payroll tax is marginal and the rate increases as firm size increases. Using a marginal payroll tax rate reduces the impact of firm expansions on employer health care costs and reduces the likelihood of perverse responses to the payroll tax among firms.

Table 3 summarizes how the payroll tax would operate.

Table 3

Employer Quarterly Payroll Taxes Under the CHOICE Program

Marginal Payroll Tax Rate	Payroll Tax on Average Payroll
1 st to the 50 th worker	5.5%
51 st worker+	6.5%

The state government will pay the payroll tax to cover state employees under CHOICE. Similarly, all municipal and county governments in the state will pay the tax for their employees. The federal government is assumed to continue to offer FEHB plans to federal employees,

²⁵ The Lewin Group, Inc. HBSM *op cit*.

²⁶ The Lewin Group, Inc. HBSM *op cit*.

however, we expect that federal workers will do whatever minimizes their costs and meets their needs (either remain in FEHB or move to CHOICE).²⁷

While all employers are required to pay the tax, an employer who continues to offer its own coverage is credited with the full amount of the tax for each worker that takes coverage under the employer-sponsored plan. The tax is also credited for workers with qualified coverage under CHAMPUS or under Medicare (for those elderly beneficiaries who do not enroll in CHOICE). However, there will be no recovery of tax payments for persons not covered under the employer's plan, including workers who are covered under a spouse's employer health plan.

Table 4 summarizes the impact of CHOICE on employer health spending for workers.

Table 4
The Impact of CHOICE on Private Employer Health Spending Before Wage Effects (millions)

	Firms That Currently Offer Coverage	Firms That Do Not Currently Offer Coverage	All Firms
Spending Under Current Policy			
Workers and Dependents	\$30,537	- - -	\$30,537
Retirees	\$2,200	- - -	\$2,200
Current Spending	\$32,737	- - -	\$32,737
Spending Under the CHOICE Program			
Employers that Retain Coverage			
Workers and Dependents	\$4,789	\$268	\$5,057
Retiree Premiums	\$2,200	- - -	\$2,200
Payroll Tax	\$20,981	\$5,200	\$26,181
TOTAL	\$27,970	\$5,468	\$33,438
Change in Employer Costs			
Net Change	(\$4,767)	\$5,468	\$701

Source: Lewin Group estimates using the Health Benefits Simulation Model, 3/25/02.

Note: Does not take into account the effects of a Medicare Demonstration Program.

The CHOICE Program is structured to reduce the potential of employers to game the system. For example, an employer could offer coverage but not contribute towards the cost of it, thus avoiding all costs. Similarly, employers could choose to offer coverage with only minimal benefits to reduce costs (there are no minimum benefits requirements for employer-sponsored

²⁷ The Lewin Group, Inc. HBSM *op cit*.

coverage under CHOICE). However, if employers makes coverage look less attractive than that available under the CHOICE Program and their employees elect not to take their coverage and enroll in CHOICE, the employer will still be responsible for the payroll tax for these workers. As a result, the health plans employers continue to offer to their employees are expected to be similar to those currently sponsored by employers to compete against the CHOICE Program.

Because the payroll tax rates that help finance the CHOICE Program are so reasonable, most firms will find that the cost of the payroll tax is less than the cost of paying for health insurance for their workers. In fact, it is estimated that only about 3 million Californians, of the 18 million who presently receive their coverage through their employer, will continue to do so, while more than 15 million will choose to move into the CHOICE Program.

F. Public Health Taxes

Three public health taxes will also be used to help finance the cost of providing health insurance coverage to Californians. The specific items to be taxed were selected based on an analysis of the major causes of disease and years of life lost in the US, which include tobacco products, injuries from motor vehicle crashes, and obesity. The public health taxes that will be collected will generate approximately \$3.3 billion to help finance the CHOICE Program.²⁸ They include:

- A state tobacco tax of \$1 per pack with a proportionate increase on other tobacco products that will yield \$1.001 billion in new revenue for the CHOICE Program.
- An increase in the state's assessment on traffic fines. Currently, the state imposes a 170% assessment and under this proposal that would increase to 607%, providing an additional \$500 million in new revenue for the CHOICE Program.
- An increase on the state tax on soda of ten cents per 12-once can. This will provide \$1.8 billion in revenue for the CHOICE Program.

²⁸ The Lewin Group, Inc. HBSM *op cit*.

G. State Safety Net Savings

Safety net spending in California was estimated to be \$4.6 billion in 2001. The state provides about \$2.3 billion per year of this funding for safety net programs that serve uninsured persons. Counties spend another \$1.2 billion on the safety net. Federal Disproportionate Share Hospital (DSH) payments total about \$1.1 billion per year. However, not all of this would be available to fund the CHOICE Program. It is critical that funding to DSH facilities is maintained and that funding is not only maintained but increased to pay for health care for persons who remain uninsured after CHOICE is fully implemented. Under the CHOICE Program, 80% of the per capita state and county safety net spending on medical care will be redirected to the CHOICE Program for each previously uninsured person who becomes covered under CHOICE. The safety net will retain 100% of federal DSH funds, 100% of current per capita spending on medical care for persons who remain uninsured, and the 20% of current per capita spending for each uninsured person who enrolls in CHOICE.

H. Other Sources of State Revenue

The other sources of revenue for financing the CHOICE Program are a quarter of a percent increase in the sales tax to generate an additional \$1 billion, and an increase in the state income tax of about 1.25% to fund the remaining \$777 million. (*n.b.*, If the NAFTA Social Integration Fund is adopted, an increase in the state income tax may not be required, as the revenue from a 2% assessment on bilateral trade between Mexico and California would generate over \$600 million (See I. below).

Table 5 summarizes the sources of funds for CHOICE, Medi-Cal and Healthy Families assuming full implementation of CHOICE in 2002.

Table 5**Sources of Funds for the CHOICE Program, Medi-Cal and Healthy Families
(millions)**

Total CHOICE and Public Program Costs		\$75,190
Program Offsets and Revenues		
Payroll Tax Revenues & Premiums		\$41,559
Employer Payroll Tax	\$31,727	
Employee Premiums	\$9,832	
Public Program Offsets		\$27,369
Federal Matching Funds	\$13,511	
Current State Medi-Cal/HF Spending	\$10,913	
Safety Net Savings	\$2,522	
State Employees Benefit Costs	\$423	
Bulk Purchasing		\$1,174
Prescription Drugs	\$1,135	
Medical Equipment	\$39	
Required New Revenue		\$5,088
Increased Tobacco Tax (\$1.00 / pack)	\$1,011	
Increased Assessment on Traffic Fines	\$500	
Increase in sales tax of 0.25%	\$1,000	
Tax of \$0.10 per 12 ounces of soda	\$1,800	
Income Tax to Fund Remainder of Program	\$777	
Increased Income Tax Rate by 1.25% (\$906)		
Wage Effect \$129		
Total Revenues and Offsets		\$75,190

Source: Lewin Group estimates using the Health Benefits Simulation Model, 3/25/0.

*Note: Does not take into account the effects of a Medicare Demonstration Program.***I. Potential Funding Under NAFTA**

NAFTA is the free trade agreement between the US, Mexico, and Canada to eliminate all tariff and non-tariff barriers to trade by 2005. Under NAFTA, US-Mexico bilateral trade increased nearly 60%, growing from \$82 billion in 1993 to \$130 billion in 1996. California has been one of the key states to benefit from NAFTA. The reduction in trade barriers and tariffs has allowed many smaller California firms to export their goods. There is a great will on the part of both the Bush Administration and President Fox of Mexico to regularize Mexicans who are in

March 25, 2002

the US illegally. Mexico recognizes that its citizens who work in the US are not only important political constituents, but also that the remittances they send from the US to Mexico constitute the second or third largest source of revenue for the country of Mexico. In addition, NAFTA has negotiated a few bilateral side agreements on the environment and on safety and labor issues. Under this proposal, another side agreement would be negotiated to address social investments including public health and health care.

The State will work with the Federal government to create a guest worker program (NAFTA+) and a Social Integration Fund under NAFTA to help finance health insurance coverage in CHOICE for Mexican citizens working in California.

1. NAFTA+ and the Guest Worker Program

President Fox of Mexico has proposed NAFTA Plus (NAFTA+), which would create a new amnesty program for the undocumented Mexicans living and working in the United States. Under this program, all Mexicans working in the US would be granted legal immigration status. In exchange, Mexico would agree to enforce regulations that would discourage undocumented immigration. All California employers who hire Mexican workers who are in the US legally would participate in financing their health care by including the wages of these workers in their total payroll which is subject to the CHOICE employer payroll tax.

2. NAFTA Social Integration Fund

NAFTA side agreements could be broadened to take into account public health and medical care issues for families from Mexico who live and work in the U.S. This expansion could be modeled on the European Union's (EU) Maastricht Treaty developed by the EU in 1993. The participating countries developed a strategy that pursues "a high level of human health protection by encouraging co-operation between the member countries" and, if necessary, by lending financial support to their action. In terms of health insurance coverage, under EU regulation, a cross-border worker is entitled to medical care benefits in both the member country in which he/she is employed and the member country in which the person resides. Similarly, under NAFTA, a health insurance program that seeks bilateral agreements could be developed. This would be financed by a social contribution from bilateral trade, which would be used to fund development projects and human development for Mexicans working in California.

Before NAFTA was enacted, duty on products and services averaged 10% in Mexico and by 1996 decreased to less than 6%. In the US, average tariffs fell from 4% to about 2.5% over

this same time period. Although the intent of NAFTA is to eliminate all tariffs by 2005, a bilateral agreement could be negotiated to create a NAFTA Social Integration Fund that required a 2% contribution on all cross-border transactions. In California, the NAFTA Social Integration Fund would be used to subsidize the cost of coverage in the CHOICE Program for Mexicans living and working in California. The amount of bilateral trade between California and Mexico in 2000 was estimated to be \$31.533 billion.²⁹ Two percent of this would yield \$630 million.

While the implementation of the CHOICE Program is not dependent on this financing under NAFTA, the adoption of a Social Integration Fund with Mexico would greatly reduce the burden on the State of California to subsidize the cost of emergency, maternity, and indigent care for Mexicans and their families who live and work in California.

VI. ADMINISTRATION AND STATE REGULATION OF THE CHOICE PROGRAM

Figure 1 details the administration of the CHOICE Program (see Appendix)

A. Administration by MRMIB

The Major Risk Medical Insurance Board (MRMIB) will administer the CHOICE Program and will coordinate with the Department of Health Services on streamlining and simplifying enrollment in Healthy Families and the Medi-Cal Program, the regulation of providers, quality assessment, data reporting, media campaigns, and community outreach. MRMIB will provide or arrange for a centralized electronic clearinghouse for claims processing, coordination of benefits, payments to providers, utilization review, quality management, and other administrative functions. Administrative costs for the ODS contracting with the CHOICE Program are expected to be about 5%, similar to costs for large group health plans. Program administration for CHOICE is estimated to be 1.2%, which is similar to PacAdvantage.³⁰

1. Enrollment in CHOICE

Workers will enroll in the CHOICE Program through their employer. The wage-based employee share of the monthly premium for workers enrolled in the CHOICE Program will be collected through automatic payroll deductions and sent by electronic funds transfer to MRMIB. The quarterly, employer payroll tax will be also collected by the CHOICE Program by electronic

²⁹ Personal communication with Joe Kafchinski, US Census Bureau, Foreign Trade Division, Feb. 6, 2002.

³⁰ The Lewin Group Inc., op cit p. 14.

transfer of funds. Medicare beneficiaries will enroll in the CHOICE through the CMS Demonstration Program.

2. Self-Certification and Automated Verification

To further reduce barriers to enrollment, all requirements for residency, work and income will be determined through a self-certification process, whereby individuals verify their information by signature, with a random paperless online verification process. Self-certification with periodic auditing has been found to be cost-effective and results in very little fraud. The costs of verification outweigh the savings in terms of decreased fraud.³¹

The implementation of an automated eligibility determination system has the potential to reduce administrative costs in Medi-Cal and Healthy Families by at least 20% and the cost of contractual agreements with the counties would be reduced by about the same amount.³²

3. Electronic Claims Submissions

All providers in the statewide CHOICE Network will be required to submit all claims electronically. We assume that the CHOICE Program will not be fully operational until 2004, at which time it is expected that 90% of health care providers and facilities/organizations will have electronic claims processing capabilities. Additional state funding to facilitate the adoption of electronic claims processing should be appropriated for the remaining 10% of health care professionals and facilities without these capabilities. Electronic review of claims submission will occur on an ongoing basis to prevent fraud and identify providers in CHOICE Network with outlier utilization profiles. Claims will also be reviewed to assess quality and costs.

4. Bulk Purchasing

Costs of prescription drugs and durable medical equipment will be significantly lower under the CHOICE Program, as they will be purchased using the federal supply schedule (FSS). It is estimated that the savings generated from bulk purchasing using the FSS amounts to 41% for prescription drugs now purchased in the private sector and savings of about 30% for drugs now purchased through Medi-Cal.³³ Similar savings will be realized from bulk purchasing of medical equipment under the FSS.

³¹ Ana Montes, Latino Issues Forum, Memo to Norma Garcia of Consumers Union re: Self-Certification, 4/20/99.

³² The Lewin Group, Inc. HBSM *op cit*.

³³ The Lewin Group, Inc. HBSM *op cit*.

B. Statewide CHOICE Network and Provider Payments

All State licensed health care providers and health care facilities will be eligible to participate in the CHOICE Network to provide covered services, but as part of their contracts they will be required to provide data on quality and costs and to participate in quality studies. All health care providers and facilities will be paid 100% Medicare fee-for-service payments. Health care providers contracting with the CHOICE Program will be paid Medicare RBRVS rates for physicians and Medicare DRGs for hospitals. This will result in increased payments to providers for patients now covered under Medi-Cal and Healthy Families. These costs would be eligible for federal match. Uncompensated care for health care providers and facilities will decline by 76%. Medi-Cal hospital payment rates will increase by 7% and physician payment rates will increase by 54%.³⁴ However, hospital payment rates will be 11% lower than private discounted fee-for-service and physician payment rates will be 4% lower than private discounted fee-for-service.³⁵

No physicians, medical groups, or hospitals contracting with the CHOICE Network will be paid capitation payments, and they will not be required to complete any paperwork for pre-authorizations, approvals or referrals.

We anticipate that nearly all physicians, other health care providers, medical groups, hospitals and other health care facilities will want to contract with the CHOICE Network due to higher payments, lower administrative costs, less uncompensated care and the tens of millions of Californians enrolled in the CHOICE Program. We also anticipate that providers will actively encourage their patients to enroll in the CHOICE Program, so that they can receive better payments for providing care than has been available from HMOs and Medi-Cal. Under CHOICE, they will be less burdened by paperwork and administration, and they will have the freedom to refer patients to specialists and other ancillary and rehabilitative services, as they deem necessary.

The CHOICE Network allows enrollees to select any participating provider at any time. While enrollees will be required to select a primary care physician (PCP) who will be held accountable for receipt of recommended preventive care and disease management, enrollees will not be required to get a referral/authorization from their PCP to visit a specialist or receive any

³⁴ The Lewin Group, Inc. HBSM *op cit.*

³⁵ The Lewin Group, Inc. HBSM *op cit.*

other covered services. Enrollees may change their PCP at the beginning of any month and the new PCP must notify the CHOICE Program of the change. Enrollees will be covered when services are received from providers in the CHOICE Network, with the exception of coverage for emergency care by non-network providers. Given the large enrollment in the CHOICE Program, we anticipate that all PCPs and the majority of specialists practicing medicine in California will want to participate in the CHOICE Network.

MRMIB will coordinate the regulation of health care providers participating in the CHOICE Network with DHS regulation of providers participating in the Medi-Cal Program.

C. Contracts with Organized Delivery Systems (ODS)

Under the CHOICE Program, the only ODS with which the State will contract are group-model HMOs, COHS, and LI plans. The CHOICE Program preserves the option of the COHS and LI plans that were created to serve the Medi-Cal population in the counties that have implemented Medi-Cal managed care. These health plans have a long track record of providing culturally sensitive, linguistically appropriate, and high quality medical care to the populations they serve. To the extent that the Medi-Cal population would like to continue to receive their medical care through these plans, and other individuals and families residing in the counties that offer these health plans would like to be able to enroll in them, the CHOICE Program will give them this option.

The reason that the CHOICE Program will not contract with IPA and network model HMOs is because they have been shown to be associated with a number of problems with respect to the efficient delivery of high quality care.³⁶ The major efficiency problems with IPA/network model HMOs include their inability to negotiate with or select high quality, efficient medical groups; their lack of physician loyalty, cohesion, and leadership; their redundant and often contradictory rules and processes; their lack of investment in the health care delivery system; and the insulation of medical groups from efficiency-enhancing market competition.³⁶ A random sample survey of consumer experiences in managed care in California found that individuals enrolled in IPA/network model HMOs reported significantly more problems in getting needed

³⁶ Singer SJ, Entoven AC. Structural problems of managed care in California and some options for ameliorating them. California Management Review, 43(1) Fall, 2000:50-65.

care, compared to those in group model HMOs or PPOs.³⁷ In another survey of callers to California's Ombudsman Service, consumers in IPA/network HMOs reported problems at a rate three times higher than for consumers enrolled in group model HMOs or PPOs.³⁸ As a result of the problems inherent in the IPA/network model HMOs, there is also substantial dissatisfaction among the physicians contracting with these plans.³⁹

While the CHOICE Program will not contract with any IPA/network model HMOs, all state licensed disability insurers or health care service plans in California will be encouraged, through tax incentives, to create new group model HMOs that may contract with the CHOICE Program. For purposes of this proposal, a group model HMO is any health services plan that offers an exclusive multi-specialty network of physicians (who provide services only to that one carrier's enrollees) and otherwise meets the licensure criteria for health care service plans in California.

The State will encourage the formation of new group model HMOs, giving Californian's more options for getting their health insurance and medical care through ODS. These new partnerships between carriers and exclusive multi-specialty groups would relate to one another in a way similar to that of the Kaiser Foundation Health Plan to the Permanente Medical Groups. In this type of arrangement, the incentives of the insurer and the physicians are more aligned, so they work in partnership to match resources to the needs of the population served; to offer comprehensive services in the most appropriate setting; to integrate and share information systems; to improve care processes; to conduct evidence-based utilization management, formulary development and continuous quality improvement; and to manage cost-benefits trade-offs.²⁰

The formation of these partnerships will require time to implement. Carriers and multi-specialty groups who partner to form new group model HMOs will be required in year one to have at least 30% of the multi-specialty group's enrollment be through the partner carrier's plan, increasing to 50% at the end of two years, 70% at the end of four years, and 100% at the end of

³⁷ Schaufler, et al Differences in the kinds of problems consumers report in staff/group health maintenance organizations, independent practice association/network health maintenance organizations, and preferred provider organizations in California. Medical Care 2000. 39(1)15-25.

³⁸ "Real problems and real solutions: Making the voices of health care consumer count," Health Rights Hotline, 1999.

³⁹ Chebab et al. The impact of practice setting on physician perceptions of the quality of practice and patient care in the managed care Era. Archives of Internal Medicine. 2001 Jan 22 161(2):202-211.

five years, achieving exclusivity.⁴⁰ The ultimate goal is to establish competing exclusive multi-specialty groups of physicians who practice in ODS and who see only patients who are enrolled in the partner carrier's plan.

Group model HMOs, LI, and COHS plans will be paid an age and sex, risk-adjusted capitation payment to address any adverse selection in the market. The funds currently used to fund the MRMIB program would be made available to fund a portion of risk adjustment payments across ODS. Self-funded employer plans would be exempt from the risk adjustment process under ERISA.

Participating ODS will be required to offer the CHOICE Program standard benefit package to CHOICE enrollees, but may also offer additional coverage. It is in their ability to increase benefits beyond those offered through the CHOICE Network that these plans will best be able to compete against each other and the CHOICE Network in the reformed market.

We also assume that disability insurers and health care services plans will develop supplemental products to provide additional coverage beyond that which is provided in the CHOICE standard benefit package, and will try to develop and market low-cost products to compete with the options available under the CHOICE Program.

D. Regulation

Regulation of the coverage offered by employers will not be affected by this proposal. The Departments of Managed Care and Insurance will continue to regulate health care service plans and disability insurers, respectively. The Department of Managed Care will license new group model HMOs, and will regulate any new supplemental or low-cost products offered by health care service plans to ensure that they meet all state mandated requirements. The Department of Insurance will regulate any new supplemental or low cost products offered by disability insurers to ensure that they meet all state mandated requirements.

E. Insurance Risk

The State bears the insurance risk for the enrollees in the CHOICE Network. State licensed group model HMOs, LI, and COHS plans that contract with the CHOICE Program bear the insurance risk for their enrollees.

F. Community Outreach

⁴⁰ Singer SJ and Enthoven AC. Structural problems in managed care in California and some options for ameliorating them. California Management Review Fall 2000. 43(1):50-65.

The CHOICE Program will work with DHS in contacting hospitals, physician offices, medical groups and clinics, as well as pre-schools, and elementary and secondary schools to ensure that persons seeking medical care, who are eligible for state programs, enroll and receive health insurance benefits. All licensed hospitals, clinics, and other health facilities, relative to an uninsured individual who is seen or admitted, will be informed about the CHOICE Program, as well as the Medi-Cal Program and Healthy Families. The individual can self-certify their eligibility and may allow an application for enrollment be submitted while they are in the hospital, clinic, or facility. A parent who gives birth to a child at a hospital, clinic, or facility will be similarly informed and provided an opportunity to submit an application relative to themselves and the child.

The CHOICE Program will permit health care providers to make eligibility determinations for a patient using an automated eligibility system. Providers will receive payment for all services provided to patients enrolled in this way, even if it is later determined that they are not eligible. Since about 55% of uninsured persons seek medical care each year, it is conservatively estimated that half of them will acquire coverage through this process.⁴¹ This would result in a 28% reduction in the number of uninsured adults and children in non-working families who are eligible for Medi-Cal and Health Families but not enrolled.

Additionally, preschools and public elementary and secondary schools will inform the parent or primary caretaker living with each child in the school at least once each year about the CHOICE Program, the Medi-Cal Program, and Healthy Families. Information will include eligibility requirements and will allow an application to be submitted at the preschool or school. There will be a simple, uniform mail-in application and enrollment process, as well as e-health electronic enrollment for all persons eligible for the CHOICE Program, the Medi-Cal Program, and Healthy Families.

IX. QUALITY AND DATA INCENTIVES UNDER THE CHOICE PROGRAM

A. Quality Assumptions

This approach differs from traditional fee-for-service care because of the way that cost and quality are factored into the CHOICE Program. First, physicians participating in the

⁴¹ The Lewin Group, Inc. Analysis of 1998 MEPS data.

statewide CHOICE Network will be required to report on both quality and cost metrics, and to participate in quality studies. Second, the CHOICE Network will include incentives for patients to migrate towards relatively high quality, affordable providers and to actively manage their own health. The creation of consumer and provider incentives for both cost and quality – i.e., value – as part of the CHOICE Network distinguishes the delivery of care in this model from others available in the California marketplace today. In addition, all health plans offered by the CHOICE Program will be required to meet any applicable standards issued by the National Committee on Quality Assurance, to provide quality data, and participate in quality studies.

B. Patient Care Management

1. Disease Prevention

The CHOICE Program covers all evidence-based preventive services. Providers in the CHOICE Network will agree to implement patient education efforts and reminders to appropriate segments of the population (e.g., women 18 and older for Pap smears every three years). PCPs in the CHOICE Network and the health plans that contract with the CHOICE Program will be encouraged to ensure that their patients receive all recommended preventive services at recommended periodicities, and at a minimum, record that the services were provided. Physicians in the CHOICE Network will be required to submit claims electronically for each preventive service provided, which will enable analysis of claims data for quality assessment. In addition, preventive services utilization will be included in quality metrics that are linked to provider incentives.

2. Management of Acute and Chronic Conditions

(a) Disease Management and Self-Care

The CHOICE Program will notify its enrollees and network providers of those provider organizations that sponsor approved disease management and self-care programs. Patients will be encouraged to participate in disease management programs through reductions or waivers in co-payments. The CHOICE Program will also evaluate the option of carve-out disease management programs that have a proven track record of success (e.g., care for patients with AIDS). The CHOICE Program will encourage patient participation in these programs by using similar incentives as those for disease management programs sponsored by providers. Additional incentives may be offered for patients who continue in a given program for a

specified period of time. For example, a patient with cardiac disease who continues to follow a provider group's approved protocol for three years may receive a premium discount.

(b) Centers of Excellence

All enrollment materials will highlight hospital centers of excellence for high volume/high cost procedures for which the literature indicates a correlation to quality. The CHOICE Program will only contract in-network with those facilities that meet or exceed evidence-based standards for these select services. Where outcomes are not yet available, volume data will be used when appropriate, and network hospitals will be required to participate in any scientific outcome studies. Examples of conditions for which there are existing data for Centers of Excellence include transplants, coronary artery bypass graft surgeries, and neonatal care units.

4. Catastrophic Care

(a) Trauma Centers/Centers of Excellence

Approved trauma centers (e.g., burn units) and centers of excellence will also be used for catastrophic care.

C. Provider Performance Measurement and Improvement

1. Quality Performance and Improvement

The measurement of quality at the physician group, individual physician, and hospital levels is still in its infancy. The quality measurement tools available today across all levels focus on patient satisfaction with care and perceived quality. Physician group measures in California include population health status and measures across select diseases/conditions, as well as utilization of preventive care. Hospital measures include C-section and perinatal mortality rates, CABG mortality rates, and several Medicare quality indicators. Notable web sites, such as healthscope.org, and hmo.ca.gov, post comparative provider performance information as it becomes available. The CHOICE Program will work with the respective sponsoring organizations of these sites to make such information interactive and available in other medium for its enrollees.

High value providers will be widely recognized during enrollment and at annual renewal and throughout the year for their performance on quality metrics (see below for patient provision of such information and bonus incentives). In areas for which there are several years of comparative data, high value providers will be recognized. In the interim, providers will be recognized for improvements, as well as for participating in measurement programs.

2. Data and Information

As mentioned above, there is a paucity of comparative provider performance information. Often such studies take several years to produce meaningful results and require substantial resources. As a requirement for in-network selection for the CHOICE Program, providers will submit relevant electronic data to participate in a study(ies) related to their practice.

D. Patient Incentives

1. Financial Incentives

Plan design is one of the most effective means of influencing patient behavior. Certainly limiting coverage to in-network providers (except in emergencies) will encourage enrollees to see providers who are willing to participate in providing data on cost and quality. As mentioned above, co-payments can be waived or reduced for patients who elect to participate in disease management or self-care programs. Co-payments will be waived for all preventive services. In addition, drug co-payments will be tied to cost and quality (see above).

2. Other Incentives

Additional patient incentives related to quality will include aggressive promotion of educational opportunities. All media, including print, the Internet, phone, and in-person discussions will be used as appropriate. The patient's condition, language, cultural perspective, health literacy, disabilities, and preferences will be taken into consideration. For example, rather than require a newly diabetic teenager to dramatically modify his/her eating habits, the teen can learn how to count the number of carbohydrates in whatever he/she wants to eat and adjust the level of self-injected insulin accordingly.

There are several off-the-shelf, highly regarded educational products that will provide patients with evidence-based treatment option comparisons and structured clinical decision-support. These include consumer videotapes from the Dartmouth Outcomes Project, condition-specific disease management materials, and commercial software from Healthwise. This type of information can be made available through a nurse advice line, in addition to print and Internet materials.

E. Provider Incentives

1. Financial Incentives

After the first year of participation, bonus incentives will be paid to providers based on (1) performance, (2) improvement, and (3) participation in quality of care studies. A bonus

scheme will be developed with input from the provider community and will be paid on top of the discounted fee-for-service reimbursement rates. It is anticipated that the bonus will be phased in to reach 10% over a three-year period.

2. Other Incentives

Other incentives include year-round recognition through press releases, an annual recognition event, and publicity during enrollment. This recognition, in conjunction with financial incentives, will strive to provide enrollees with information on “best of class” providers at the point in which they are making decisions about care.

X. CHOICE IMPLEMENTATION APPROACH AND FEASIBILITY

No Federal waivers are required for the implementation of the CHOICE Program. No ERISA waiver is required to adopt a new state payroll tax. And there is no individual mandate to have insurance coverage.

A. Implementation Steps

Implementation of the CHOICE Program will require:

- contracting with licensed health care providers and facilities who elect to participate in the statewide CHOICE Network;
- a simplified and coordinated administrative process for enrollment and eligibility, including self-certification with paperless verification and health e-app;
- a system for the collection of the quarterly employer payroll tax, and the monthly worker share of premium;
- development of a media campaign and community outreach strategy to inform Californians about CHOICE and how to enroll; and to increase enrollment in the Medi-Cal Program and Healthy Families for those who are eligible.
- a system for electronic claims processing and review.
- payments to providers in the CHOICE Network.
- contracts with ODS (licensed group model HMOs, COHS, and LI plans) and the development of an age and gender, risk-adjusted capitation payment;
- development of a fee structure for licensed insurance brokers who enroll self-employed workers in the CHOICE Program and who enroll all workers in a small firm (<50 workers) in the CHOICE Program.

- development of a proposal for a CMS Medicare Demonstration Program to permit elderly Medicare beneficiaries to enroll voluntarily in CHOICE and pay the premium.

B. How CHOICE Affects Current Coverage and the Health Care Market

The CHOICE Program leaves in place Medicare, the Medi-Cal Program, Healthy Families, employer-sponsored coverage, and the group and individual health insurance markets. Through the voluntary actions of uninsured workers, and as a result of outreach to individuals eligible for but not enrolled in Healthy Families and the Medi-Cal Program, the CHOICE Program is likely to increase overall coverage rates to 94.4% of the California residents regardless of their legal status. If the program were implemented in 2002, it is estimated that the number of uninsured Californians would be decreased by 4.8 million.⁴² At the same time, the CHOICE Program offers employers strong economic incentives to transition much of the non-elderly covered population into one of two systems: the statewide CHOICE Network or eligible ODS (group model HMOs, COHS, and LI plans).

It is estimated that the number of persons enrolled in the CHOICE Program within one year of implementation would be approximately 22.4 million Californians (Figure 2).⁴³ We anticipate that the number of persons covered by commercial PPOs and IPA/network model HMOs will decline over time, and the number of employers who offer health benefits is also expected to decline over time. Within a year of implementation, it is estimated that the number of persons receiving their health insurance through their employer in the group market will decline from 18.4 million to 3.1 million Californians.⁴⁴ In addition, the number of Californians purchasing private health insurance in the individual market is estimated to decline from 1.6 million to 565,000 within a year of implementation. It is estimated that enrollment in Medi-Cal and Healthy Families will drop from 4.4 million to 3.1 million Californians, with the remainder enrolling in CHOICE.⁴⁵

⁴² The Lewin Group, Inc. HBSM *op cit.*

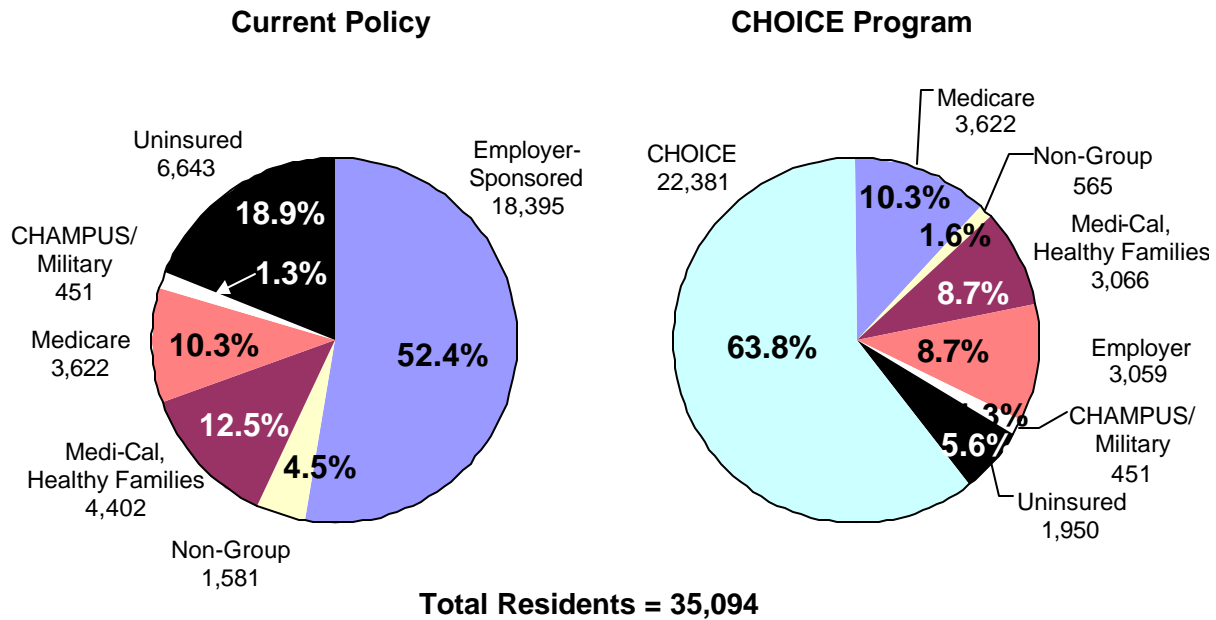
⁴³ The Lewin Group, Inc. HBSM *op cit.*

⁴⁴ The Lewin Group, Inc. HBSM *op cit.*

⁴⁵ The Lewin Group, Inc. HBSM *op cit.*

Figure 2

Distribution of California residents by Primary Source of Coverage Under Current Policy and the CHOICE Program in 2002 (in thousands)



Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM), 3/25/02
 Note: Does not take into account the effects of a Medicare Demonstration Program.

Finally, safety net providers will be less dependent on direct state subsidies for indigent care, providing services to a predominantly insured population and counties will be paid at a higher rate per uninsured person for indigent care for the remaining uninsured.

Adoption of the CHOICE Program does not automatically replace any existing coverage. However, it provides all non-elderly California workers and their non-working dependents, as well as elderly Medicare beneficiaries, with the option of replacing their current coverage with the CHOICE Program, if they choose.

Under CHOICE, there are tax incentives for health insurance carriers and health plans to partner with multi-specialty groups in exclusive arrangements to create new group model HMOs in California. It is likely that the group model HMO market will grow through the formation of new ODS to compete with the existing group model HMOs, LI and COHS plans. It is estimated that approximately 46% of the enrollees in the CHOICE Program will elect to get their care through ODS with 52% selecting the statewide CHOICE Network.⁴⁶ The individual health insurance market will have to compete with the CHOICE Program and it may not be able to do

so effectively unless the health plans can develop and sell a product that is less expensive than and competitive with the benefits, out-of pocket costs of the monthly premium, and co-payments under the CHOICE Program. It is estimated that participation in the individual health insurance market under CHOICE will decline from 1.6 million to 565,000.⁴⁷ There is also the opportunity for commercial health plans to develop and market supplemental products for coverage that exceeds the standard CHOICE benefit package.

C. How CHOICE Affects the Safety Net

California will maintain its commitment to safety net providers through continued state, county and federal funding for indigent care programs for those who remain uninsured. In addition, safety net providers will be strongly encouraged to participate in the CHOICE Network, where they will receive 100% Medicare RBRVS payments that are 54% higher than those currently paid by Medi-Cal or considerably more than is available through indigent care funding.⁴⁸ In addition, COHS and LI plans will be eligible to contract with the CHOICE Program, retaining these options for Medi-Cal recipients who are presently enrolled in them, and opening access to these plans for others in the counties they serve, also receiving risk-adjusted capitation payments that are significantly higher than Medi-Cal payment rates.

The CHOICE Program will quickly reduce the number of uninsured people in California, and, commensurately, there will be fewer and fewer people needing indigent medical care. It is the intent of the CHOICE Program to be able to substitute Medicare payments under CHOICE for indigent care funding for previously uninsured Californians. This approach will provide the safety net with a much more stable source of financing in the long run by offering higher payments for covered services and it will enable all safety net providers to deliver more comprehensive, high quality health care to all of their clients. In addition, the state will increase its commitment to better fund the safety net in the counties by increasing the per capita funding for those who remain uninsured.

⁴⁶ The Lewin Group, Inc. HBSM *op cit.*

⁴⁷ The Lewin Group, Inc. HBSM *op cit.*

⁴⁸ The Lewin Group, Inc. HBSM *op cit.*

Appendix to CHOICE Option